DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 1 9 HA

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 22, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(a)(13)(A) of the Social Security Act, 42 CFR 447, Subpart C; 447.253,271

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 5.1 million
b. FFY 2001 $19.5 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A
Page 158.2

**SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New Page

10. SUBJECT OF AMENDMENT:
Additional Payments for Nominal Charge Hospitals

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Exempt pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:

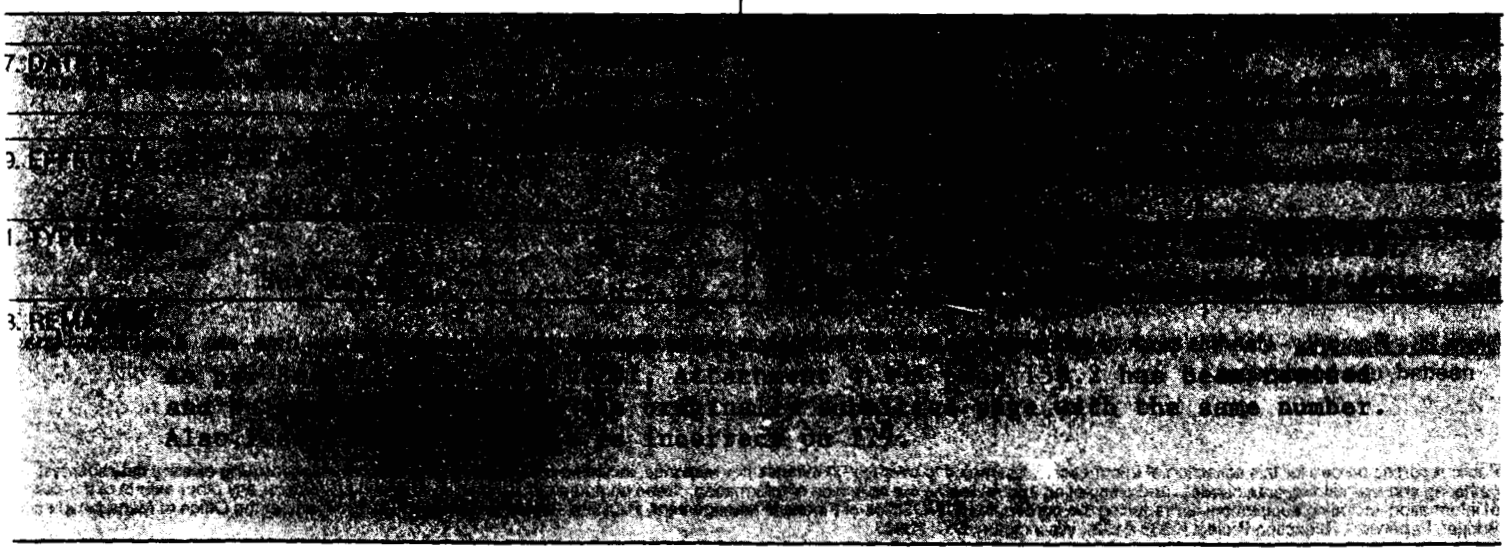
13. TYPED NAME:
Michele K. Guhl

14. TITLE:
Commissioner

15. DATE SUBMITTED:

16. RETURN TO:

Division of Medical Assistance
and Health Services
P.O. Box 712
Trenton, NJ 08625-0712



FORM HCFA-179 (07-92)

Instructions on Back

11.1 Additional Payment for Nominal Charge Hospitals

a) Any New Jersey acute care hospital that has been recognized by the New Jersey Medicaid program as a nominal charge hospital for three prior years, and which has had a Medicaid fee-for-service utilization greater than 30 percent in its first finalized cost report for the hospital's fiscal year ending during 1995, shall be eligible to receive enhanced payments for providing inpatient services to New Jersey Medicaid and New Jersey FamilyCare-Plan A fee-for-service beneficiaries.

b) Effective for services rendered after July 21, 2000, interim payments shall be made in equal lump sum amounts according to a monthly schedule, based on an estimate of the total enhanced amount payable to a qualifying hospital, subject to cost settlement.

c) Final enhanced payments shall be determined at cost settlement, and shall be calculated as follows: $2,150 per Medicaid inpatient day, adjusted by a volume variance factor (the ratio of expected Medicaid inpatient days to actual Medicaid inpatient days for the rate year) and subject to a pro rata adjustment so that the total enhanced per diem amounts are equivalent to the total annual State and Federal funds appropriated in the amount of $52 million.

New Page

JUN 06 2001
JUN 06 2001
TN 00-19 Approval Date
Supersedes TN New Effective Date 7/22/00